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No. 282.—Vol. XXIV, No. 4.] [APRIL, 1912.

THE BRITISH JOURNAL OF DERMATOLOGY

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THE BRITISH
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APRIL, 1912.

TRICHOSPOROSIS NODOSA.

By J. M. H. MACLEOD, M.D.

The specimens of hair which form the subject of this communication were obtained through the kindness of Dr. E. Minett of the Government Bacteriological Department, George Town, Demerara,

Fig. 1.—Drawing of hairs affected with Trichosporosis nodosa.

British Guiana, and were hairs from an aboriginal Indian girl, of the tribe Atavy, living in the Rupununi District. The hairs were black in colour, rather fine, and presented on the shaft a number of hard nodules varying in size from minute specks like particles of grit up to small pins' heads (see Fig. 1). In some cases the nodules were so small as to be scarcely visible to the naked eye, but however small, they could invariably be felt by pulling the hair through the free borders of the nails of the thumb and one of the fingers. The nodules were roughly oval in shape, brownish-black in colour, hard, firmly attached, and either situated on the side of the hair-shaft or formed a concretion completely ensheathing it.

They varied in number from two to three to a dozen or more and were distributed irregularly on the shaft, sometimes close to each other, and at other times at considerable intervals. They were most numerous at some distance from the scalp and were stated to be absent on the intra-follicular portion of the hair.

Microscopical Appearances.

When softened in liquor potassæ and examined under a low power of the microscope, the nodules were found to consist of a mass of spores forming a concretion which was at first entirely outside the cuticle of the hair (see Plate, fig. 2). Later, as the concretion increased in size, it appeared to exert a destructive action on the cuticle and even on the cortex, separating the cells, causing the surface of the hair to become frayed and rendering it liable to fracture opposite them. With a higher power (Plate, fig. 3) the mass was observed to be made up almost entirely of spores, no definite mycelial filaments being detected. These spores were usually large and were recognised as being most probably those of the fungus to which Behrend gave the name of Trichosporon giganteum. These had a strikingly regular arrangement. At the periphery of the nodule they were oblong in shape, about 12 μ in length and 6 μ in breadth, and were arranged at right angles to the hair-shaft so as to form a pallisade layer, while next the hair they were irregular and polygonal in outline, and tended to be arranged like the cells of a honeycomb or a mosaic. In some instances there was a peculiar fan-like grouping with rows of spores radiating from a central base. The spores had a yellowish appearance owing to the presence of diffuse colouring matter and pigment granules in the protoplasm, and were held together in a mass by a viscid cement substance which formed a sort of capsule enclosing them.

Cultivation.

Cultivation experiments were done with the kind assistance of my colleague, Mr. W. Topley, Bacteriologist, Charing Cross Hospital, and a characteristic culture was eventually obtained by soaking small pieces of the hair containing nodules for five minutes in absolute alcohol and planting them on proof agar. Nodules were also grown on broth and gave a white flocculent culture, which when planted on proof agar gave the same growth as that obtained directly. The agar tubes were inoculated in a cool incubator at about 16° C. About a week after the inoculation a small white, solid speck, about the size of a large pin's head, appeared on the surface of the medium; this increased in the course of a week to the size of a split-pea, and assumed a greyish-green tint which spread from the centre to the

FIG. 2 (low power).

FIG. 3.

Specimens soaked in liquor potassæ.

FIG 4.—Culture of Trichosporosis nodosa on proof-agar.

TO ILLUSTRATE DR. MACLEOD'S PAPER ON TRICHOSPOROSIS NODOSA.

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periphery and had a slightly powdery surface but no marked duvet. In the course of another week the culture had reached the size of a sixpence, forming a heaped-up roundish mass with a crenated nodular border, and the greyish tinge had become replaced by a brownish colour which gradually darkened to that of milk chocolate (Plate, fig. 4).

Microscopical preparations from the culture in broth showed irregular branching mycelial filaments with spores at varying intervals and "endogonidia" containing small spores of different sizes and granules (Fig. 5).

FIG. 5.—Irregularly branching mycelium and endogonidia from culture of Trichosporosis nodosa in broth.

[NOTE.—The specimens of hair were demonstrated at the meeting of the Dermatological Section of the Royal Society of Medicine in July, 1911, and a culture at the meeting in December, 1911 (see *Transactions*).]

The cultural appearances corresponded with those which were obtained by Minett, who found that the fungus gave a cloudy growth on broth, which under the microscope looked like branches of oblong spores with very few branching filaments, the spores being "ovoid in shape, with a long tail resembling a drumstick, and many of the filaments having spores at each end." On glucose agar a white growth was obtained from each of the nodules which gradually changed in colour to brown.

General Remarks.

There seems to be little doubt that the condition above referred to is identical with that which was described and frequently occurs in the valley of Canca, in Columbia, where it is known on account of the stony hardness of the concretions as "Piedra." It has been observed also in other parts of South America. According to Minett, it is rare in British Guiana, and occurs only among the aboriginal Indians upon the Brazilian border, being confined to women, and so far he has never met with it amongst the white, black or coolie women in the Colony. It has been observed also in India and Ceylon (Castellani).

A closely allied condition has been known for many years in Europe, both on the Continent and in this country, where it has been described under a variety of names, such as Tinea nodosa (Morris and Cheadle), Piedra nostras (Unna, Behrend and Trachsler), Trichomycosis nodularis (Duhel-Renoy), and in all probability it was the "chignon fungus" (Beigel and Tilbury Fox). In the tropics it generally affects the scalp-hairs of native women, but it has been found also on the eyelashes and the hair, moustache and beard in men; in most of the cases met with in temperate zones it has affected the beard or moustache.

The tropical cases are usually due to a large-spored fungus of the type of Trichosporon giganteum (Behrend). According to Castellani the Ceylon cases are caused by a fungus somewhat different from it. The descriptions of the fungi observed in the European cases vary somewhat in detail and point to the conclusion that the condition may result from a number of allied fungi.

In the Tinea nodosa described in this country by Morris and Cheadle the beard and moustache were affected, and the concretions were made up of spores which were "smaller than those of a trichophyton of ringworm." In the "Piedra nostras" case of Behrend, the fungus, to which he gave the name of "Trichosporum ovoides," had oval spores 3 to 4 μ in length which grew easily on potato in the form of white colonies, the medium assuming a brownish tint. In Unna's case the fungus was somewhat similar to that described by Behrend, gave a yellowish-white culture on agar, and was named "Trichosporum ovale."

Pernet, in 1900, succeeded in cultivating the fungus from the

moustache, and his description corresponds closely to the above in so far as the microscopical appearances were concerned. On proof agar the culture had a central portion of brownish hue, greatly contorted and heaped up with a vermicelli appearance, and surrounded by an opaque-whitish zone with gyrate borders beyond which the growing fungus radiated, the delicate rays terminating in a fluffy dendritic manner.

The origin and means by which the fungus is implanted on the hairs are uncertain. It is known to be contagious, and it has been suggested that it may be spread by the mucilaginous fluid resembling linseed oil with which the native women dress the hair.

In British Guiana the natives attribute it to bathing in certain white or milky waters, and state that if they bathe in the brown peat bush-waters it does not occur.

Diagnosis.

Trichosporosis nodosa has to be distinguished from the more common affection, known as leptothrix, which was described in England as early as 1869 by Paxton, and subsequently named by Erasmus Wilson. Considerable confusion has arisen between these two conditions, which are quite distinct, on account of certain names which have been applied to leptothrix such as Trichomycosis nodosa (Patterson), Trichomycosis palmellina and Trichomycosis tropica (Castellani). In leptothrix the hairs of the axilla and occasionally the scrotum are involved, and the condition is much more common than Trichosporosis nodosa. It is frequently associated in the axillæ with red sweat, the moisture in those parts appearing to be an important factor in its development. In leptothrix the hairs, instead of having a nodose appearance, are thick, irregular, and ragged, owing to the presence of concretions on the surface which are broken up into lobes arranged roughly like the barbes of a feather, or form irregular masses of a reddish-brown tinge. The hair itself is eventually affected by the concretion, which causes a splitting up of the fibres and a tendency to fracture in a brush-like manner. These concretions, instead of being made up of spores, appear to be chiefly composed of a cement substance, which becomes hard and chitinous, and is somewhat allied to that which fixes nits to the hair shaft. This cement is believed to be secreted by a micro-organism, and various

microbes have been described in connection with it, such as bacilli (Patterson and Payne) and a diplococcus (Sonnenberg and Eisner), but so far none has been definitely established as the cause.

Castellani observed it in Ceylon, where it affects the axillæ and presents three varieties, which he has named Trichomycosis flava, nigra, and rubra, the commonest being the yellow and black varieties. According to him the yellow is due to a bacillary-like fungus, probably a streptothrix or a microsporoides, which he was unable to cultivate. The pigmentation in the yellow and black varieties he attributes to coccus-like organisms which produce black and red pigments and grow on the hair in symbiosis with the streptothrix. The black pigment-producing coccus is easily cultivated, and for it he suggested the name *Micrococcus nigrescens*; the red pigment-producing coccus somewhat resembled the *Micrococcus ruber* of Trommsdorff found in cases of chromodrosis.

Treatment.

The treatment of Trichosporosis nodosa is unsatisfactory chiefly on account of the practical difficulty of removing the concretions from the hair, and the condition never shows any tendency to spontaneous recovery. The treatment indicated is somewhat similar to that employed for the removal of nits from the hair, and consists in the application of some solvent such as benzine, turpentine, paraffin or petrol followed by a thorough washing with soap and water. This procedure, however, seldom effects a cure, and it is generally necessary to resort to the more drastic measure of shaving the scalp or cutting the hair short. When this is done the disease is said to recur when the hair grows unless some antiseptic precautions are taken with the object of preventing any of the spores which may be left about the scalp growing on to the hairs again. Consequently after the hairs have been cut short it is necessary to apply daily some antiseptic remedy to the scalp such as 1 in 8 carbol-glycerine, 1 in 2000 perchloride of mercury solution, or a 3 per cent. ointment of ammoniated mercury.

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CLINICAL NOTES.

RODENT ULCER AFFECTING THE RETRO-AURICULAR SULCUS.

By J. H. SEQUEIRA, M.D., F.R.C.P., F.R.C.S.

On March 21st, 1912, a healthy-looking man, aged thirty-eight, presented himself in the Skin-Department at the London Hospital

suffering from a growth behind the left ear. His general health had been good, but he stated that he had had a "wart" behind the left ear for the past eight years. During the last ten months he had noticed that the wart had been growing, and it had recently spread so that it had become visible above and below the auricle. Movement of the ear had been attended with pain, and from time to time there had been slight hæmorrhage.

On examination I found that the retro-auricular sulcus was occu-

Fig. 1.

pied by a narrow tumour filling up the space between the mesial aspect of the auricle and the adjacent scalp. The width of the growth varied from 10 to 15 mm. Its margins were pinkish in colour, smooth, and crossed by fine capillaries. On endeavouring to pull the auricle forward a linear ulcer was exposed, the least movement causing slight hæmorrhage. At its upper end the growth turned forwards over the top of the attachment of the auricle, and presented a characteristic beaded growth which projected slightly on to the temporal region. Under the lobule there was a similar forward

extension forming a rounded smooth excrescence the size of a pea. In both situations the surface of the growth was smooth, and under a lens fine capillaries could be seen crossing the surface. The nearest glands were not enlarged. The photographs show the situation of the growth. In Fig. 1 the black rounded spot is a small piece of lint stained with blood. This piece of lint covered the site of a portion of the growth which was removed for microscopical examination.

Fig. 2.

Report on the histology of the portion removed (Dr. Turnbull).

Basal carcinoma (rodent ulcer) of skin of ear.—The nodule is covered by epidermis with rather long, narrow, interpapillary processes. In the centre is a depression filled by horny *débris*. The growth extends inferiorly to the limits of the section. It consists of processes which vary greatly in size and shape. They are for the most part rounded. They are very frequently arranged in a network. The processes are composed of very uniform polygonal, oval or squamous cells with a relatively scanty protoplasm. The external

cells are usually columnar. They have large oval nuclei. The nuclei have a fine net of faintly stained chromatin. They occasionally have a large nucleolus. Karyokinetic figures are present. The stroma is abundant and fibrous. It shows very little infiltration by plasma-cells and eosinophiles. Portions of the stroma and even of the adjacent growth show œdematous degeneration with some granular necrosis and pyknosis. The interpapillary processes of the epidermis are in parts continuous with the processes of the growth.

The interest of the case lies (1) in the situation of the growth and its peculiar limitation to the sulcus behind the ear, and (2) in the fact that the patient had experienced so little discomfort. I think it is obvious from the nature of the tumour that its growth had been very slow. Its position and the fact that the surface was quite smooth would render it liable to be overlooked by the patient. The interesting observations of Mr. Lenthal Cheatle on the relationship of the spread of rodent ulcer and some other cutaneous growths to nerve areas led me to consider whether there was such an influence in this case. The actual area occupied by the growth is supplied by two

cutaneous nerves, the great auricular from the cervical plexus which sends twigs to the mesial aspect of the greater part of the lobule, while the tip is supplied by the small occipital nerve, according to Hirschfeld and Leveillé's diagram of the nerve supply of the head and neck.

I could find no evidence of the involvement of the cartilage, and propose to curette away the whole growth and then apply the X-rays or radium to the base, as may be found most convenient. Should this fail it will probably be necessary to remove the auricle.

TINEA TONSURANS IN A PATIENT OF ABOUT SIXTY.

By GEORGE PERNET, M.D.

Whilst looking through some old notes, I came across the following details of a case which had escaped my memory:

In May, 1900, a lady of about 60 consulted the late Radcliffe-Crocker for a scurfy condition of the scalp and an alopecia of one year's duration. He made the following notes of the condition (Case Book, J. 284): The scalp was much denuded of hair, which was quite white, slightly reddened and very scaly.

I examined some of the bent and broken hairs, which he found mixed up with the seborrhoic condition.

The following are the notes I made at the time (Derm. Notes, No. IV, T): After soaking the hairs in liq. potassæ, I found they were stuffed with sporulated, segmented mycelium. Here and there where the hair had given way at the side, and outside the hair, bits of mycelium and individual segments and spores in twos and threes could be seen; also similar elements scattered about the field (by pressure of cover-slip). At the proximal end the mycelium was distinctly inside the hair and was plain. The elements scattered about varied in size, some being longish segments. This preparation I stained and handed to the late Radcliffe-Crocker, but as I have not got any of his slides I cannot say what has become of it.

From the microscopical appearance I made a diagnosis of Trichophyton megalosporon endothrix, which I confirmed by cultivation at the time.

Though an old case, I think it is worth while placing it on record.

ROYAL SOCIETY OF MEDICINE.

DERMATOLOGICAL SECTION.

Meeting held on Thursday, March 21st, Sir Malcolm Morris, K.C.V.O., President of the Section, in the Chair.

Dr. Haldin Davis showed a case of *Raynaud's disease associated with calcareous degeneration*. The patient, a married lady, aged 34 years, had suffered from chilblains all her life and from Raynaud's disease for many years. During the last seven years, however, hard swellings or nodules have appeared from time to time on the fingers of both hands. These nodules, which at first were quite granular, gradually increased in size until they stretched the skin, which became shiny over them, and ultimately gave way with the formation of a small opening. Through this opening there then poured a constant discharge of calcareous material in tiny pieces not larger than millet-seeds. Commonly the swellings when once opened became infected, and continued to discharge pus mingled with calcareous material for an indefinite time. This secondary inflammation made the lesions very painful. Two fingers, one on each hand, have been definitely shortened owing to the loss of tissue from long-continued suppuration. Not only have the fingers been affected, but a similar swelling has also formed on the right elbow, which after attaining a greater size than the swellings on the fingers has gone through similar changes, and has now been discharging for about ten months. When she was shown, in addition to three swellings of considerable size on the fingers, there were numerous small and painless nodules which were evidently the first stages of new lesions of a nature exactly similar to the former. On examination of the fingers by the X-rays the calcareous deposits may easily be seen on the screen.

The toes were unaffected. The patient's general health was good; she has a baby ten months old, which she was able to suckle without difficulty for over six months, and which she only weaned because her doctor thought that it was making her fingers worse. In this connection it is interesting to note that the fingers first became troublesome when she was nursing her first and only other baby, which is now eight years old. Both the children were quite healthy.

Since the case was shown Dr. Parkes Weber has drawn Dr. Davis's attention to an exactly similar case which he published in conjunction with Dr. Scholefield in the *British Journal of Dermatology* for September, 1911 (vol. xxiii, pp. 276–281). His patient was a single lady, aged 50 years. His article is illustrated with skiagrams of the hands, and he has given references to the other cases of the same affection previously published. There seem to be only about four papers on the subject. Dr. Parkes Weber was also good enough to get Dr. Dorner to examine chemically the calcareous material derived from my case, and he finds that it consists of calcium carbonate and phosphate. No uric acid or urates have been detected.

Dr. Adamson said that he had not seen a case of this sort, but that it seemed to resemble some cases which had been described of recent years in France as "subcutaneous calcareous granulomata" (Dufour, Milian), and in Germany as "chalky metastases in the skin" (Jadassohn). Histologically the lesions in these cases had been found to be granulomata with giant-cells, with the central part of the lesion occupied by chalky matter, and it had been suggested that they were infective granulomata. Another view was that the chalky deposit was the result of some metabolic disturbance, and that the granuloma resulted from the presence of this deposit. Full references to the literature of these cases, of which about a dozen had been recorded, would be found in the latest edition of Clifford Allbutt and Rolleston's *System of Medicine* (p. 545).

Dr. Whitfield said Dr. Briscoe had an unilateral case of multiple calcareous nodules, with a definite history of trauma. It had been apparently a septic lymphangitis, which calcified, but the process was progressive. The nodules consisted of lime-salts. The patient was treated for a long time with phosphoric acid, which prevented any more lesions from forming, though it did not take any away. This case might be worked out on Joulie's method. In reply to Dr. Pernet, Dr. Whitfield said that after the extensive use of Joulie's method he could only report one favourable result.

Dr. Dawson said calcareous deposits in the skin were not very uncommon. At present he had a patient with a plaque on the forehead, which he cut out, and a large one the size of a penny in the hip. It was still there, and had not caused trouble. That which he cut out was composed of gritty material.

The President said his opinion was that tophi in gouty people were not now as commonly seen as formerly. When he was younger he frequently saw people with gouty deposits—in the ear, for example—and a well-known member of the medical profession had gouty deposits in the ears, and he could take out of his ear a piece of chalk and write on the blackboard with it. He did not know whether that coincided with the views of other members.

Dr. Whitfield agreed with the President's remark as to the comparative rarity of gouty tophi at the present time.

Dr. Midelton said he believed it was the opinion of most spa practitioners that there was not now so much arthritic gout seen as previously; the disease seemed to be now attacking the nervous system more.

Dr. J. L. Bunch showed a case of *congenital xanthoma*. The patient, a boy, first came under his care at the Queen's Hospital for Children in December last. He was then six months old, and the history was that when a few weeks of age a small yellowish tumour had made its appearance on the scalp, and had gradually increased in size. It had been painted with iodine, and, when seen, was about the shape of a small bean, and was covered with a fine scale, no doubt due to the treatment. Soon after the appearance of the first tumour others began to come, both upon the scalp and upon the face, chest and shoulders. The mother is sure that no swelling has at any time diminished in size spontaneously, or shown any tendency to disappear. While the child has been under Dr. Bunch's care several fresh swellings have shown themselves, and even during the past ten days a new one of small size has come on the arm. These swellings were from the very first yellow in colour, with a smooth, slightly glistening appearance, they were firm to the touch, and were evidently situated entirely in the skin. The largest lesion was situated on the scalp, it measured about three-quarters of an inch in its longest diameter, was flattish on the surface, and had not quite the same elastic feel that some of the other tumours had. The most noticeable and most disfiguring one was situated on the margin of the right ala nasi; it was roundish, yellow, and projected prominently from the skin, as if a pea were placed upon it. There were several others on the neck, chest, back and arms, varying in size from the large one on the scalp to the size of a millet-seed, and of different degrees of prominence. One had been excised for microscopic purposes, and some others treated by solid carbon dioxide. The urine contained no sugar.

Sections showed a tumour involving the cutis and subjacent tissue and pressing out the overlying epidermis and flattening the papillæ. The tumour consisted of a large number of cellular elements, some of which contained xanthomatous pigmented material and a few giant-cells associated with newly formed connective-tissue fibres. Some of the capillaries appeared to be filled with cells resembling those which lined the capillaries, and which were, therefore, of an endotheliomatous nature. Some of the cells were granular, but these granules were not always pigmented. At the sides of the tumour the elsewhere flattened epithelium tended gradually to regain its normal characteristics, until it faded off into that of the surrounding healthy, normal skin.

He added that the structure was mesoblastic, very similar to that shown in the drawings of sections which Mr. MacDonagh figured in his paper in the *British Journal of Dermatology*, which included the description of a case which Dr. Bunch had shown recently at a previous meeting. In that case there were more than a hundred such tumours present, and they were of a much redder tint than those shown to-day. The sections of that case differed from the one now under the microscope in that they showed no giant-cells or hyaline masses with

sharply defined nuclei which resembled giant-cells. He desired to draw attention to the difference which these cases showed from the ordinary Xanthoma planum, and also to thank Mr. MacDonagh for cutting the sections.

Dr. E. Greaves Fearnsides (for Dr. Henry Head) showed *a case showing an abnormal condition of the nails of the hands associated with secondary carcinomatosis.* Rachel G—, aged 39 years, a married woman, had been under observation at the London Hospital under the care of Dr. Henry Head since November, 1910. The patient stated that she was in-patient at the German Hospital in May, 1910, and that for abdominal

tumour and uterine hæmorrhage hysterectomy was performed. Three months after the operation she developed ascites, and for this was admitted (in November, 1910) to the London Hospital under the care of Mr. Jonathan Hutchinson. Whilst an in-patient paracentesis was twice performed. On the first occasion thirteen pints, and seven days later fifteen pints, of amber-coloured fluid were obtained. The fluid removed was found to contain an excess of endothelial cells.

In August, 1911, she was first seen by Dr. Fearnsides. She showed a considerable degree of ascites and much fairly generalised bronchitis; the glands of her left groin were greatly enlarged and adherent to subjacent tissues; the glands of her right groin were also considerably infiltrated. She was gravely wasted; her liver was not palpable, and there was no enlargement of the axillary or cervical glands. She expectorated freely. An examination of the sputum failed to reveal the presence of any tubercle bacilli.

In October, 1911, two glands were removed from her right groin and sent to the Pathological Institute [S.D. 1059, 1911]. On section these cut like a potato. The surface of the larger was in places

white and smooth, in others granular and showed several small cystic spaces with ragged margins. The surface of the smaller was smooth, flat, firm and pearly white. On microscopic examination these glands show many cystic spaces into which project numerous villous processes. The processes and the rest of the wall of the cysts were covered by one or more layers of cubical or columnar epithelium. The pathological diagnosis of the gland was "secondary, papillary, cystic, cubical and columnar-celled carcinoma of the glands of the groin." Whilst under treatment the bronchitis has cleared. During the last four months her finger-nails have become thickened, irregular, opaque, and horny. The change was first noticed just in front of the nail-bed. She has not lost flesh.

At the present time she was thinly covered. There was considerable ascites. The glands of both groins and both axillæ were greatly enlarged, firm, hard and adherent to surrounding tissues. The liver could not be felt. The heart was not enlarged. There was no abnormal dulness over the chest, and but few adventitious sounds were audible over the lungs. The urinary and nervous systems were unaffected.

The portions of the finger-nails which have grown during the last three months were thickened, or opaque and horny. The rate of growth of the nails in recent times has been slow. The distal portions of the nails were fairly normal. The nails of the toes were to some extent affected, but not to any grave degree. The skin elsewhere showed no gross abnormalities.

A Wassermann test performed on March 6th gave an entirely negative reaction.

Dr. Pernet pointed out that on the nail of the little finger there was a distinct transverse white band. He remarked that in a particular case* which the late Radcliffe-Crocker brought before the old Society, one of Acanthosis nigricans, Dr. Pernet had pointed out a rather broad transverse white band of nails. The interesting point was that Acanthosis nigricans was certainly almost always associated with some malignant disease. Dr. Crocker's patient had some sort of abdominal growth (? pyloric malignant disease), and he died. He was not operated upon and there was no necropsy.

Dr. Colcott Fox presented a case which he diagnosed as *Hebra's prurigo* in a baby girl, aged 15 months. This child is stated by the mother to have suffered from whooping-cough and varicella since

* *Brit. Journ. Derm.*, 1899, vol. xi, p. 116.

Christmas. The prurigo eruption began about two months ago. Intensely itching typical papules were seen disseminated chiefly on the legs and arms, and the groin glands were palpable.

Dr. Fox said he thought the case interesting to bring before the Section, because he thought it supported the opinion which he had long held, that this type of prurigo began as seen this day, and was not preceded by urticaria or the Lichen urticatus of Bateman. He thought he had obtained similar evidence in early cases in older children, and some years ago he had recorded cases of Lichen urticatus lasting years, and he had never seen one become a prurigo of Hebra. The mother of this baby was certain that no antecedent urticaria or Lichen urticatus ushered in this prurigo eruption. The mother was confident on this point without any prompting on the part of the exhibitor, and adhered to it on questioning.

Dr. Stowers recalled the series of cases which the late Mr. Morrant Baker and he collected for the purpose of demonstrating that prurigo (or Hebra's prurigo, as it was called) existed among us as a substantive disease, although generally overlooked in consequence of the secondary dermatitis which supervened. He was glad to know that Dr. Fox's views corresponded with his experience, and hoped that special attention would be paid to the characteristic features, which were well marked in the case exhibited.

Sir Malcolm Morris showed a case of *Dermatitis herpetiformis*. The patient was a female, aged 48 years, who came under his care first in January, 1904, when she was forty, for Dermatitis herpetiformis. Her skin was xerodermic, and she had suffered from rheumatic fever on three occasions, the last time eight years before he first saw her. The type of the attack has varied. At the commencement there were erythematous patches and vesicular groups of lesions on the arms and legs, especially round joints, but later vesicles and bullæ. She began to take arsenic in July, 1904, and since that time has taken the drug in varying doses according to the severity of the eruption. When the arsenic was left off the eruption became worse, and when the dose of the arsenic was increased the eruption began to abate.

The disease has been quiescent for about a year. She has had during that time slight groups of vesicles on the fingers only. She has not taken any arsenic during the quiescent stage. She has suffered from slight chronic arsenical poisoning as a result of the amount she has taken.

She has typical arsenical palms and soles and she has pigmentation on the skin. At the end of 1905 she had bronchial catarrh and conjunctivitis and the arsenic had to be stopped for some weeks, but during that time the eruption was severe. Since that time smaller doses of arsenic held the eruption in check.

Dr. WHITFIELD said he had a case like this, which he had been seeing for five or six years. On the whole, he though it was uncommon for Dermatitis herpetiformis to be absolutely controlled by arsenic, but he was able to regulate his case with mathematical accuracy. On 7½ ♏ *per diem* she was no better; on 15 ♏ she was a little better, and on 22 ♏ she was well. He had tried many other remedies, but nothing else controlled it. She had slight arsenical palms and marked arsenical neck, and his difficulty was to know whether he ought to allow her to have the skin disease or the arsenic, with its disabilities. The case had been worked out by Joulie's method, but it was of no use. The Joulie ratios were disturbed in all urticaria conditions, to which this disease was more or less allied. These patients showed a very low phosphate ratio. That was put right in his case, but it made no difference to the skin-disease.

Dr. PERNET said that in severe cases with intense, maddening paroxysmal itching, insomnia, etc., and when the patient was in a very bad way, lumbar puncture was indicated.

Dr. COLCOTT FOX said the cause was very obscure. His brother always thought the disease was neurotic. Two of his original cases died in asylums. He, the speaker, did not know whether the cause was a chronic toxæmia or a neurosis.

Dr. GEORGE PERNET showed a case of *Xantho-erythrodermia perstans* (*Crocker-Pernet*). The patient was first seen by him in 1903 (*Case-book C.* 472). The complaint had then been present some four years. He labelled it in his notes at that time as an anomalous condition, with perhaps some affinities with Lichen variegatus (Parakeratosis variegata and so forth), though the condition differed from the latter in various ways (distribution, appearances, etc.). On November 9th, 1904, the patient was kind enough to come before the old Dermatological Society of London, when Dr. Pernet demonstrated the case under the title of Xantho-erythrodermia perstans, a name suggested by him, and for which he made no apology, as he considered it appropriately descriptive in the present state of our knowledge of this obscure condition. The details of the case as then shown will be found at large in the *British Journal of Dermatology* for 1904 (vol. xvi, p. 457). This case was included in the ten instances described in the synthetic paper of the late Radcliffe-Crocker, who adopted the name suggested, viz. Xantho-erythro-

dermia perstans (*Brit. Journ. of Derm.*, 1905, vol. xvii, pp. 119–134). Another case (No. 8 of the late Radcliffe-Crocker's paper) Dr. Pernet saw and followed up with his old friend and teacher at the hospital. Appended to his paper will be found a histological note on a biopsy of skin he (Dr. Pernet) made at the time (*loc. cit. supra*, vol. xvii, p. 134), but little was gathered from his microscopical examination. The patient now shown was practically in the same state he was in when he was first seen nine years ago. A course of X-rays he had at that time had no effect on the complaint. Fortunately he suffered no inconvenience whatever and is in perfect health.

Dr. Sequeira showed (1) *a case for diagnosis*. The patient was a married woman, aged 40 years, who had had four children. Two had died in infancy from "bronchitis" and two were alive and in good health. The youngest child was eight years old. Since the birth of this child the patient had had two miscarriages respectively at the fourth and third month. Five years ago she had suffered from pneumonia and pleurisy. She was admitted to the London Hospital on March 9th, 1912, with the history that a rash had appeared upon her body three months before. The eruption appeared to have been of an erythematous character, and was said to have followed the taking of conger eel. Her hair had been falling rapidly since the outbreak. The eruption had steadily spread and no part had disappeared.

On admission there was an eruption covering the chest, abdomen, and the back, the upper limbs as far as the wrists and the thighs down to the knees on the anterior and inner surfaces. In the more central regions the eruption consisted of closely placed atrophic, oval or rounded, pearly white depressed spots surrounded by a narrow erythematous margin. Each spot was about one third to half an inch across. On the extremities the central white areas were not present, the rash consisting of smaller macular erythematous spots which became slightly scaly soon after admission. The face was quite free, and there was no eruption, cyanosis, or other change on the skin of the extremities.

Before admission there was a good deal of irritation, though there had been none since. The hair was very scanty and had been falling rapidly. The scalp was slightly scurfy.

On the front of each leg there were scars of old ulcers, some of

which suggested tertiary syphilitic lesions. The Wassermann reaction, however, was negative, and beyond the miscarriages there was nothing to suggest syphilis.

Soon after admission the temperature rose on one occasion to 100·3° F. without apparent cause. The bowels acted regularly. The catamenia had been irregular for some months. The urine (catheter specimen) had a specific gravity of 1015, and contained a trace of albumen. There was no sugar. The blood examination showed: Red cells, 4·18 millions; hæmoglobin, 70 per cent.; colour index, ·8; leucocytes, 8000; polynuclears, 68 per cent.; eosinophils, 0·5 per cent.; small lymphocytes, 6·5 per cent.; large lymphocytes, 14 per cent.; large hyaline cells, 11 per cent.

There was no other evidence of visceral disease, and the mouth was unaffected. The case might be classed as an atrophying erythema, and the condition of the skin was probably the expression of a grave toxæmia. The patient was obviously very ill, and she was brought to the meeting with some difficulty as she was unable to walk owing to weakness.

The absence of any affection of the face and extremities, the exhibitor considered, placed the case in a somewhat different position to the acute forms of Lupus erythematosus.

Dr. PERNET thought the case came into the category of Lupus erythematosus, on account of the albuminuria, the cold extremities, the rises of temperature, etc. With regard to the origin of the condition, in the paper which he wrote on acute pemphigus* he mentioned the case of a man who developed acute pemphigus after eating putrid conger eel.

Mr. MACDONAGH said there was a case in St. Bartholomew's Hospital in 1907 absolutely identical with this one. It was under Dr. Drysdale, and was admitted for skin trouble associated with periodic rises of temperature. The skin condition consisted of an erythema, which gave way to discrete papules which in time became atrophic in the centre. The hair, as in the case shown, also fell out. During her stay in hospital patient not only got rises of temperature, but attacks of erysipelas and herpes developed in other parts of the body, all of which improved under quinine. Some months later she was admitted with pneumococcal pericarditis, for which she was operated upon, and died. The diagnosis was Lupus erythematosus, followed by acute pneumococcal infection and death.

(2) A case of *Lichen planus annularis*. The patient was a woman, aged 56 years, a private maternity nurse. She was married and had had nine children, six of whom were alive. There were no mis-

* *Brit. Journ. Derm.*, 1896, vol. viii, p. 209 (foot-note 24).

carriages. The skin affection had been present for three or four years. It began upon the left leg with intense itching, and gradually involved the right leg and then the forearms. She was treated at Guy's Hospital two years ago and had improved after some months' treatment. She was transferred to Dr. Sequeira by Dr. Theodore Thompson on February 20th.

The eruption was widely spread over the extremities and presented a number of annular areas about half an inch across, formed of smooth, shining, flat-topped papules. Between the rings there were numerous isolated papules and occasionally irregular plaques formed by the aggregation of numbers of the papules. There was a copious eruption of small white papules on the buccal mucosa.

There were no general symptoms except headache and pain in the back, which had persisted since the menopause, three years ago.

Dr. Sequeira commented upon the number of cases of Lichen planus which he had seen recently both in his hospital and private practice.

Dr. Galloway said that he had drawn attention two or three years ago to the occurrence of Lichen planus in patients suffering from the chronic forms of glycosuria. Whenever the skin disease was found to occur in a stout patient, he thought the possibility of glycosuria should immediately arise in the mind of the physician and the requisite investigation be made. Recently he had had the opportunity of seeing several cases of Lichen planus within a short space of time, and one of the most wide-spread attacks occurred in a lady aged about 50, who was both stout and had glycosuria.

Dr. Colcott Fox said a remarkable case was demonstrated by Dr. Cavafy at the Old Dermatological Society of London, showing unquestionably individual papules becoming circinate, but confluent patches of papules becoming circinate was more frequent.

Dr. Fearnsides and Dr. Sequeira showed *cases of double cervical ribs associated with vascular phenomena suggesting Raynaud's disease.*

(1) Dr. Fearnsides (for Dr. H. Head) showed a case of *double cervical ribs associated with raso-motor disturbances (Raynaud's phenomena) of left forearm and hand and of right hand, with slight wasting and weakness of muscles of left hand.* Rebecca D—, a married woman, a "cutter out by trade," aged 41 years, has been under observation at the London Hospital under the care of Dr. Henry Head since July, 1911. She complained of pains in the left forearm shooting down the inner side of the limb into the hand, tingling in the tips of the fingers

of the right hand, and attacks of redness, blueness and lividity of the forearm, arm and fingers on the left side, and of right hand, accompanied by local sweatings of the affected portions of the limbs, and general nervousness.

The patient stated that as a girl she was subject to "dead fingers" of her hands, but that the left hand was always more liable to these than the right. In youth and early married life she was only subject to these attacks of "dead fingers" when the weather was extremely cold.

In December, 1910, in consequence of family troubles, she had to change her occupation. Almost immediately afterwards she became subject to sharp pains shooting along the inner side of the left forearm, dragging sensations in the left axilla, and feelings of numbness and pins and needles in the fingers of the same side.

Shortly after this she noticed that the nail-beds of the fingers of the left hand had altered, the lunulæ of the nails had become reddened, and she became subject to attacks of pain in the fingers of the left hand.

In January, 1911, she had a "nervous breakdown," with great weakness and an inability to stand, of mental origin. She attended as an out-patient at the National Hospital, Queen Square. In February, 1911, she was sent thence to a convalescent home. Since that time her general condition has improved, but the local pains and vaso-motor disturbances (attacks of blueness, greyness and lividity of the left hand, and to a less severe degree of the right hand) have become more and more troublesome.

Lividity with vaso-motor spasm and pain can now readily be elicited from the left hand and forearm by exposing the hand to relative cold. The small muscles of the left hand and the muscles of the inner side of the left forearm have, during the time the patient had been under observation, become definitely weak and slightly wasted.

Present state. — Introspective; emotional. Whilst in-patient in January, 1912, the patient had two "minor hysterical attacks," with emotional display, temporary blindness, and complaint of headache and choking, followed by amnesia of the attack itself. Speech unaffected. Headache chiefly occipital, not constant; occasionally also vertical "opening and shutting" headache. Lower limbs unaffected. Slight

but definite wasting of muscles of thenar and hypothenar eminences, of interossei on left side. Left grip feeble, right fair. All muscles act on volition, though the power of the small muscles of hand is small on the left side. Electrical reactions: all muscles react normally to coil and cells; no fibrillary twitchings seen. To tests with cotton-wool, heat, cold, vibrations of a tuning-fork, and passive movements, no discoverable sensory loss. To pin-prick, loss of acuity in sensation along inner border of left forearm; edges indistinct and cannot be mapped. The tendon reflexes on both sides from arm and leg are all extremely ready. The plantar response on both sides is flexor in type. Fundi unaffected. Cranial nerves good. Sphincters unaffected.

In general the left hand is blue, and has a sodden, moist, clammy appearance. On exposure of the limb to relative cold the hand becomes mottled, blue or purple, and the finger-tips assume a grey-blue colour. The change in vascularity on exposure is limited to the lower half of the left forearm, the left hand and the fingers of this side. In recent times a similar but less marked mottling has appeared under similar circumstances over the right hand and wrist.

The pulses in the two radial arteries are equal and synchronous. The subclavian vessels in the neck are not over prominent Urine natural. Hæmoglobinuria never observed. There is no palpable cervical rib on either side, but in the radiograph on each side there appears a well-developed cervical rib.

(2) Dr. Sequeira.—The patient, a married woman, aged 29 years, had had two stillborn children, one at full term and one at six months. She had always had good health. For the past eight years she had noticed a mottling of both arms extending from the upper arm to the finger-tips. Both arms were affected equally. There was no pain, and no uneasiness, and there was no apparent alteration of sensation. The muscles of the hands were not wasted. The mottling was curiously located to the inner side of both hands and forearms; it had a purplish-blue colour. There was no general mottling of the extremities, though the patient stated that occasionally she had had some lividity about the knees. The curious distribution of the cyanosis, in view of the cases which had recently attracted attention in neurological circles, led the exhibitor to have a radiograph

taken. This showed that the patient had a rudimentary but well-defined cervical rib on each side.

The association of cervical ribs with vascular phenomena was now a well-established fact, and it suggested the examination of the neck by radiography in doubtful cases of Raynaud's disease.

Dr. Galloway desired to support the observations made by Dr. Sequeira and Dr. Fearnsides. Some of the members present might remember the case of a young man with supernumerary cervical ribs, who came from time to time to Charing Cross Hospital, and who had been the subject of more than one demonstration. This patient, a young man, was originally sent to Dr. Galloway on account of what was supposed to be a pulsating tumour on the left side of the neck above the clavicle. The tumour turned out to be the subclavian artery supported on a well-developed cervical rib. This patient suffered from unusual "neuritic" sensations in the left arm and hand, especially felt on the outer and inner borders, and there was possibly also some loss of power in the muscles of the thenar and hypothenar eminences. When the arm was in the dependent position there was also a tendency to stagnation of the blood in the extremities. The phenomena of interference with the nerves and with the blood-vessels in the posterior triangle of the neck by a cervical rib were well recognised, and attention had been drawn to them in various interesting papers by Sir William Osler and others. The symptoms were sometimes so pronounced that they simulated such conditions as erythromelalgia and even Raynaud's disease, and in the diagnosis of these two latter conditions the possibility of the occurrence of a supernumerary cervical rib should always be borne in mind. The symptoms associated with interference of the blood supply through the subclavian artery and the return of blood through the subclavian vein could easily be understood, but the reticulate erythema shown in one of Dr. Sequeira's cases could only be looked upon as the result of long-standing congestion of the skin such as might occur from many causes, and could hardly be considered as a vaso-motor disturbance due to the influence of the cervical rib. In Dr. Galloway's patient already referred to there was a supernumerary cervical rib also on the right side which appeared to give rise to no disturbance. Since the use of X-ray examination many cases of cervical ribs have been proved to exist which appeared to give rise to no trouble.

Dr. F. Parkes Weber said that Dr. Fearnsides' case was very similar to one which he showed at the Medical Society of London on April 26th, 1909. In his (Dr. Weber's) case there were cervical ribs on both sides, but the phenomena in the hand-muscles were much more marked on the right than on the left side. The cervical rib on the right side was afterwards removed, and though the result from the operation was at first not satisfactory, there was some improvement later on. The patient's brother and sister were both found to have cervical ribs, though they had not any atrophy of hand-muscles. Dr. Sequeira's case looked different from that of Dr. Fearnsides'; the mottling or "Livedo annularis" was not present in Dr. Fearnsides' case or in his own; in Dr. Sequeira's case there was no wasting in the thenar or hypothenar eminences or in the interossei; and there were no sensory symptoms (pain or paræsthesiæ) whatever. Dr. Weber thought that "Livedo annularis," such as was present in Dr. Sequeira's case, was

not dependent on the presence of cervical ribs, though the localisation to symmetrical areas on the upper extremities was very striking.

Dr. Whitfield showed horizontal and vertical sections of the skin of a kitten affected with *microsporon ringworm*, and also a culture grown from the hair of a child who had been infected by the kitten. The sections were stained with lithium carmine, and after stained by Gram's method, and decolourised with hydrochlorate of aniline dissolved in aniline oil. The specimens showed that the fungus had the ordinary arrangement of the microsporon as regards the mosaic of spores surrounding the hair and lying within the internal root-sheath. Invasion of the hair-shaft was, however, very slight, the fungus maintaining an almost purely ectothrix position. The skin before being cut and stained showed no characteristic bald or partially bald places, and the hair was not broken. Microscopically it could be seen that only a very small proportion of the hairs was infected, differing in this respect very materially from the condition that obtained in the child. The culture showed a peculiar silky growth, with very marked radiating striæ, and absolutely no folding of the surface, thus differing from both the microsporon Audouini and the microsporon lanosum of the dog.

Clinically there were some points which had led Dr. Whitfield to suspect the kitten and have it examined. The chief of these was that the disease had started in the child with a very heavy infection of the glabrous skin in the form of large rings. This was of course quite unlike the course of events in the ordinary microsporon infection.

Dr. Colcott Cox agreed with Dr. Whitfield's remark concerning kitten ringworm producing Tinea circinata of the skin. He possessed a drawing of such a case, with great rings all over the body.

Dr. Bunch asked Dr. Whitfield what was the relative proportion of kitten ringworm in which the microsporon was present. In a paper on "Ringworm Infection in Man and Animals" he had published reproductions of cultures obtained both from the patient and the kitten (the source of infection), but that was an endothrix, and he would be very interested to know whether Dr. Whitfield had come across a similar case.

Dr. Pernet said he had brought a case of Tinea circinata contracted from a half Persian kitten before the old London Society in 1904.* In the scrapings from the patient the fungus corresponded to microsporon Audouini and material

* *Brit. Journ. Derm.*, 1904, vol. xvi, p. 347.

he had obtained directly from the kitten (ears) when examined by him showed numerous small spores arranged about the hairs as in microsporon Audouini.

Dr. Whitfield, in reply, said he was not at all familiar with ringworm in the kitten, but it seemed a very difficult condition to diagnose. A large piece of the skin of the kitten was sent to him by Professor Hobday, the veterinary surgeon, and it showed no obvious sign of the disease. There were no rings of any kind in it, nor bare patches. On microscopical examination of horizontal sections it was found that about only one hair in twenty or thirty was affected, and it was therefore quite possible to overlook kitten ringworm. Dr. Bunch's case of endothrix in a kitten was, he believed, the only case of the kind on record. He did not know of Dr. Pernet's case.

MANCHESTER DERMATOLOGICAL SOCIETY.

Ordinary Meeting, held February 23rd, 1912, Dr. R. B. Wild in the Chair.

The minutes of the last meeting were read and passed. The following cases were shown :

Dr. R. B. Wild : (1) *Lupus erythematosus* in a girl, aged 13 years. She also suffered from Tinea tonsurans. The lesions presented were two symmetrical erythematous patches, ringed in shape, on each cheek ; there was also a similar patch, somewhat triangular in outline, on the bridge of the nose. The lesions on the cheek showed marked plugging of the follicles and a tendency to slight atrophic changes.

(2) *A case of sclero-dactyly associated with Raynaud's disease.* Dr. Wild had previously shown this case to the Society when she had numerous ulcers on the hand, with one or two erythematous lesions on the arms, and also a pustular infection of the scalp with loss of hair.

At that time some of the members expressed the opinion that the case was one of Lupus erythematosus.

At the present date the lesions on the head had quite disappeared and there was a growth of new hair over the whole of the previously bald patch. The condition of the hands had much improved, but there were still one or two small-sized ulcers.

Mr. Savatard showed (1) A man, aged 81 years, with *multiple epitheliomata* (eight) scattered over the face and neck. Some of the smaller non-ulcerated lesions presented the characteristic pearly

outline of rodent ulcer. Large crateriform ulcers (epithelioma) had been excised from the right cheek and behind the left ear. Behind the ascending ramus of the jaw was a large, hard, lobulated mass, firmly fixed to the surrounding structures (simulating secondary carcinomatous invasion of the cervical glands). This the exhibitor had diagnosed clinically as a carcinoma originating in the sebaceous glands. This diagnosis was confirmed by histological examination.

(2) A *case of cutaneous neuro-fibromatosis* in a man, aged 32 years. Most of the lesions (rounded and sessile) had appeared two years previously on the trunk; more recently others appeared on the extremities, and still more recently a few had arisen on the face and scalp. There were large, scattered, *café au lait* patches on the trunk, and a large pendulous mass on the posterior aspect of the left thoracic region. The exhibitor considered this last to be an unusual form of the same condition.

There were no subjective symptoms nor any apparent fibrosis of the peripheral nerves nor nerve tumours to be felt. There was no history of a similar condition in any relative. The patient's intelligence was apparently below the average.

(3) *A case for diagnosis.* A youth, aged 17 years, presented a series of depressed atrophic scars, varying in size from a bean to a pin-head, on the left cheek. These scars began three quarters of an inch below the left external canthus, and extended downwards to the angle of the jaw. In the lower part some slight capillary dilation was to be seen. The condition began over the malar region two years previously. There was a slight erythematous appearance on the right cheek. The hands and feet showed venous stasis with marked hyperidrosis.

The lesions on the left cheek had been treated with solid CO^2 previous to his attendance at the hospital. The patient's mother had been a patient at the hospital twenty years previously for extensive Lupus vulgaris.

Dr. WILD thought the case was an unusual form of Lupus erythematosus and the exhibitor was inclined to agree.

(4) A case of *acute Lupus erythematosus* on the face, ears, and upper extremities. The scalp was not involved. There was a tuberculous family history. Some of the lesions on the fingers had been

treated continuously for the last fortnight with 5 per cent. tuberculin ointment, without apparently any reaction or absorption.

(5) A man, aged 30 years, with *syphilitic œdema* of the upper lip, which was resolving rapidly after an intermuscular injection of salvarsan; previous prolonged treatment with mercury and potassium iodide had had no result.

Mr. SAVATARD thought that it would be of interest to the meeting to hear that the case he had shown at the last meeting of the Society as an epithelioma arising on lupus scar tissue had proved, on examination, to be a spindle-celled sarcoma.

Dr. LANCASHIRE showed the case which he had brought to the notice of the Society at their last meeting as a case of *Lichen planus bullosus*. The lichen papules had now cleared, leaving on the arms, back and legs the staining which is usual after Lichen planus. On the legs and feet, however, were bullæ and raw surfaces, evidently the result of the rupture of previously existing bullæ. These bullæ were of the appearance of those seen in pemphigus. They arose from apparently healthy skin, were tense, and filled with clear serum, and had no surrounding inflammatory zone. It was suggested that the patient might be suffering from Lichen planus and pemphigus concurrently.

THE GOULSTONIAN LECTURES.

THE Goulstonian Lectures at the Royal College of Physicians this year have been given by Dr. H. G. Adamson on "Modern Views upon the Significance of Skin-eruptions." It is nearly forty years since a dermatologist was Goulstonian Lecturer, Dr. R. Liveing delivering his classical lecture on leprosy in 1873. We heartily congratulate Dr. Adamson on the honour conferred upon him, and upon his admirable exposition of the modern developments of dermatology.

VOYAGE D'ETUDES MÉDICALES. 1912.

THE second tour to the mineral water and climatic stations of France will take place from September 1st to 14th, 1912, under the personal supervision of Professor Landouzy. It will comprise the central stations and those of the Auvergne, to be visited in the following order: La Motte-Beuvron (sanatorium), La Roche-Posay, Néris, Evaux, La Bourboule, Mont-Dore, Saint-Nectaire, Vic-sur-Cère et Le Lioran (stations climatiques), Royat, Durtol (sanatorium), Chatel-Guyon, Vichy, Bourbon-l'Archambault, Bourbon-Lancy, St-Honoré-les-Bains, Pougues.

For further information please address Docteur Carron de la Carrière, 2, Rue Lincoln, Paris; or Docteur Jouaust, 4, Rue Frédéric-Bastiat, Paris.

CURRENT LITERATURE.

THE WASSERMANN REACTION IN SYPHILIS, LEPROSY, AND YAWS. Major Horace D. Bloombergh, United States Army. (*Philippine Journal of Science*, October, 1911, vol. vi, p. 335.)

These observations were undertaken with a view of determining if the Wassermann reaction could be obtained in certain tropical diseases in which it has been reported by some authors to be positive. Owing to a scarcity of material at the time the work was being done, only two cases of yaws were examined. The methods employed for making the tests followed in general the original procedure of Wassermann except as regards the antigen, which was prepared from normal guinea-pig heart. Sheep are not slaughtered in Manila, and fresh sheep's blood from different animals cannot therefore be obtained. The cells used in all the tests were obtained at different times as needed from the blood of the same sheep. Only during the last series of tests did the suspicion arise that the sheep had been bled too frequently, and therefore the cells were fragile and less resistant than usual to the combined influence of amboceptor and complement.

The complement was the serum of a guinea-pig killed on the day of the test.

The hæmolytic amboceptor was the inactivated serum of a rabbit which had been immunised by successive doses of well-washed sheep cells.

The actual technique of the reaction as carried out did not differ from that usually employed. On all occasions on which the reaction was made, a positive syphilitic and a normal serum were used as the main controls of the effective specific action of the reagents. The sera were likewise tested to determine whether they, independently of the antigen, bound the complement, or whether they were actively hæmolytic with cells alone, or in the presence of complement.

In all, ninety-five cases were examined. Of these the following seventy-six gave negative results:

Number of cases.	Clinical condition.	Number of cases	Clinical condition.
18	Leprosy.	1	Suspected leper.
17	Syphilis or suspected syphilis.	1	Exophthalmic goitre.
9	Syphilophobia.	1	Otitis media chronic.
5	Dysentery, amœbic, chronic.	1	Pemphigus.
2	Dysentery, amœbic, acute.	1	Rheumatism, muscular.
1	Dysentery, bacillary, acute.	1	Gastritis, alcoholic.
2	Rheumatism, articular chronic.	1	Neurasthenia and syphilophobia.
		2	Dengue.
1	Iritis.	1	Ulcer of the leg.
1	Malaria, tertian acute.	1	Fever, type undetermined.
1	Rodent ulcer.	1	Osteoma of the tibia.
1	Liver abscess.	6	Healthy Filipinos.

It will be observed that in the above list a certain number of cases were tropical diseases of a protozoal or presumably protozoal nature.

The seventeen cases in which clear luetic histories were obtained, but which

gave a negative Wassermann reaction, were, to a certain extent, disappointing, although the results were not out of accord with the findings of some other observers. The three following are of interest among the syphilitics who gave negative reactions:

One case was a patient who had severe general rupial lesions and whose serum was examined one week after the administration of salvarsan ("606"). The case reacted negatively. However, it must be stated that the patient had been for a long time on very vigorous treatment with mercurials.

Another, which had been under mercurial treatment only three or four days, reacted negatively. This soldier originally had a chancre in the inner canthus of the eye in which one of the Board had demonstrated *Treponema pallidum*. The reaction was made shortly after the appearance of a rash.

A third case of more than passing interest was that of right-sided hemiplegia, undoubtedly syphilitic, occurring in a young man who gave a history of a typical primary lesion, the usual secondaries, an iritis, and finally, almost two years after infection, a hemiplegia with aphasia. This patient had been thoroughly under treatment with mercurials and iodide, particularly for the month or so preceding transfer to the Division Hospital. The Wassermann reaction was negative. That the condition was really syphilitic was demonstrated to our satisfaction by the marvellous improvement which the patient showed after treatment with salvarsan.

The remaining fourteen syphilitic cases which gave negative reactions had all been under treatment for several months.

The following is a list of the twenty cases which gave a positive Wassermann reaction:

Number of cases.	Clinical condition.	Number of cases.	Clinical condition.
5	Syphilis, secondary.	1	Dementia præcox.
7	Syphilis, tertiary.	1	Periostitis, chronic.
3	Leprosy.	1	Rheumatism, acute articular (probably syphilitic).
2	Yaws.		

Major Bloombergh considers it doubtful if a positive Wassermann reaction is to be obtained as a result of infection with the *Bacillus lepræ*. Before attributing a positive reaction in a leper to his leprosy alone, it is necessary to consider the possibility not only of syphilitic taint but also of present or antecedent frambœsia. This latter is especially important when working with leprosy in those parts of the Tropics where yaws is prevalent. Recently he has seen a Filipino leper who also showed typical lesions of yaws.

In yaws he was able to make observations on only two individuals. In one, a young Filipino adult in the active stage of the disease, the diagnosis was based on the clinical appearances and on the presence of *Treponema pertenuë* in the nodules. The second serum was obtained from a ten-year-old boy who had long been a frequenter of the skin-clinic at St. Paul's Hospital in Manila. Both of these sera gave the same strong inhibition of hæmolysis that was obtained from untreated syphilitic cases. The finding confirms the results of many others who

have tried the serum reaction on yaws. It will be of interest to add that seven days after treatment with "606" the serum reaction of the second case remained positive. Evidently the time was not sufficiently long for the substances in the blood arising from the activities of the *Treponema pertenuë* to disappear. Incidentally, the recovery in this case was remarkably rapid, although the boy had done very poorly on the iodide of potash treatment given him at the clinic over a period of more than a year.

Of the syphilitic cases which gave positive serum reactions, few had ever been on mercurial treatment and not one had been recently treated.

References to papers on the Wassermann reaction in leprosy are given.

J. H. Sequeira.

DIE DÄNISCHEN TRICHOPHYTEN UND IHRE STELLUNG IN SABOURAUD'S SYSTEM. Bang. (*Verhandlungen des ersten Nord. Dermatolog. Kongress*, p. 9.)

That the varieties of the ringworm fungus differ very much in their frequency in different countries has long been recognised. In this paper Dr. Bang, of Copenhagen, describes the forms which he has met with in Denmark.

In twelve of his fourteen cases of favus the disease was localised to the hairy scalp. Besides scutulum formation he had two cases of Favus pityrodes and one case of Favus impetiginodes. He found the Achorion Schonleinii twice on the glabrous skin, the diagnosis from tinea being only made by cultures.

The Microsporon Audouinii is rare, but the author describes an epidemic affecting fifty children which occurred in 1906.

The Microsporon equinum of Bodin he finds frequently derived from the horses of cavalry regiments.

Of the endothrix trichophyta he has had nine cases of Trichophyton violaceum in the scalps of children between three and nine years of age.

The Trichophyton neo-endothrix, variety plicatile, appears to be common. It is the cause of almost all the beard ringworms met with in Copenhagen. It occurs in four forms—(1) rounded, dry spots; (2) impetiginous lesions; (3) infiltrated sycosiform suppurating lesions often associated with (2); (4) round or oval kerion-like plaques. Of fifty cases, thirty-nine affected the beard and two the scalp. Sabouraud had only seen two cases of T. plicatile, but he recently demonstrated it in Sequeira's case of trichophytic granuloma.

Of the ectothrix trichophyta the common varieties are—(1) T. gypseum asteroides, and (2) T. faviforme discoides. The former Bang has found in the scalp forming kerion lesions, and in other instances scaly patches. The T. faviforme discoides was found in cases derived from the horse, thrice in the scalp of children, and once in the beard and twice on the glabrous skin.

The author also mentions a case of Trichophyton purpureum occurring in the groin in a male, aged 27 years. He does not mention if this patient had been in tropical countries.

J. H. Sequeira.

ON THE SALVARSAN TREATMENT OF SYPHILIS. G. Frank Lydston. (*New York Med. Journ.*, October, 1911.)

Having from the first leaned toward the side of conservatism and having waited until he felt that his own experience warranted him in forming conclusions, possibly what he now has to say of salvarsan comes with better grace than it

would if he had received with open arms the new drug as the remedy that was destined to wipe syphilis off the map.

From careful observation he is convinced of the great value of salvarsan in meeting the following indications:

First—Prompt removal of severe genital lesions, thus lessening, first the danger of infecting others; second, the danger of detection; third, local discomfort; fourth, the danger of serious local complications of a destructive character.

Second—The prevention or prompt removal of disfiguring skin-lesions.

Third—Precocious or malignant syphilis and obstinate destructive bone and cartilage lesions, especially of the face and nose.

Fourth—Cases resistant to or intolerant of mercury. In this class of cases salvarsan is often of inestimable service.

Fifth—Early nerve and brain and all visceral lesions, with the exception of renal syphilis in which he considers salvarsan especially dangerous. In late lesions of the nervous system its use may occasionally be justifiable.

Sixth—Cases of syphilitic cachexia or anæmia, which often consist of a combination of over-treatment and syphilis.

Seventh—Severe and rapidly destructive lesions of the throat and obstinate lesions of the tongue.

Eighth—Syphilis involving the organs of special sense, excepting lesions involving the retina.

Ninth—Early tabes or exceptionally in late—not terminal—cases in the hope of relieving severe pain or involvement of the sphincters.

Tenth—Infantile syphilis. J. L. B.

A RÉSUMÉ OF ONE HUNDRED WASSERMANN TESTS. John A. Roddy. (*New York Med. Journ.*, September, 1911.)

This series is composed of equal numbers of private practice and hospital cases, patients such as are met in the general practice of medicine and surgery. A review of those cases discloses some interesting facts.

In this hundred cases 90 per cent. of the patients were between twenty and forty years of age; the youngest was two, and the oldest sixty-eight years of age.

Wassermann and others have pointed out the futility of making extremely sensitive complement-fixation tests, but they have in no way shown any undesirable feature in tests which are quantitative as well as qualitative. Most of the complement-fixation tests made at the present time are only qualitative. The tests here reported have all been quantitative, the complement-fixation power of the patient's sera being tested by adding different amounts of complement. One tenth cubic centimetre of patient's serum was put in each of three tubes; to the first 0·15 c.c., to the second 0·1 c.c., and to the third 0·05 c.c. of guinea-pig serum was added. No originality is claimed for this method; it has been advocated by others. Roddy wishes to show that by testing a fixed amount of patients' sera with several different amounts of complement, different degrees of complement fixation power can be recognised, the influence of medication can be more accurately estimated than in any other way, and, in about 5 per cent. of cases, errors which are unavoidable in simple qualitative tests are precluded. Six cases out of the hundred showed hæmolysis when 0·1 c.c. of patient's

serum was mixed with 0·1 c.c. of guinea-pig serum, but showed no hæmolysis when 0·1 c.c. of patient's serum was mixed with 0·05 c.c. of guinea-pig serum. Had an opinion been formed from the result of a single mixture of equal quantities of human and guinea-pig sera, which is a common practice, it would have been erroneous in each of these cases.

The only instance in which a positive Wassermann finding was apparently contradicted by other features of the case occurred in the serum of a Hindoo, confined in a hospital on account of hook-worm infestation, which was examined and gave a positive Wassermann and a positive Noguchi reaction. We have learned, through personal communications from those working where ankylostomiasis is a common disease, that non-syphilitic patients infested with hook-worm frequently show positive Wassermann reactions.

J. L. B.

TWO CASES OF ORIENT BOIL (CLOU DE BISKRA). Hodara and Fuad Bey. (*Derm. Wochenschr.*, No. 1, January 6th, 1912, p. 16.) (With two illustrations.)

Although the clou de Biskra is well known as occurring in certain districts, these have not so far included the neighbourhoods of Caesarea and Angora, and the two cases now published are therefore of special interest.

The first case was that of a soldier, aged 20 years, of Caesarea, who for eleven months had had on his left cheek a soft, red swelling, about 2 cm. in diameter, in the centre of which was a thin, black crust, superimposed on a pfennig-sized, round erosion. This appearance had apparently been present for a long time. From all preparations of the discharge, whether serum, pus or blood, a pure culture of a diplococcus could be obtained and no other micro-organism. Neither in the discharge nor in sections could Wright's bodies (so-called *Heleosoma tropicum*) be found. Excision entirely cured the lesion. Sections showed a granulomatous structure and a hypertrophic epidermal layer, but no transformation of cutis-cells into hyaline bodies, as described by Riehl. Otherwise the appearances were similar to those described by Leloir, Herxheimer, and Bornemann.

The second case was a woman of Angora, who had had a similar lesion on her right cheek for two months without changing much in appearance. In this case, after staining with Giemsa (diluted with two thirds water), the *Heleosoma tropicum* could easily be demonstrated, staining light-blue or sky-blue, and distinguishable from the cell-nuclei, which of course stain violet. In the centre of the Heleosoma its nucleus could be seen as darker-staining chromatin bodies, occasionally crescentic or semi-circular in shape.

This case of course corresponded to the well-recognised Aleppo boil, and inasmuch as it appeared clinically to be exactly similar to the Caesarea boil, Hodara insists that this latter was also a case of Aleppo boil, with the same pathogenesis and the same exciting cause.

J. L. B.

CULTIVATION OF THE LEPROSY BACILLUS. Major Rost, I.M.S., and Capt. Williams, I.M.S. (*Scientific Memoirs of Government of India*, No. 42, and abstract by H. B. Newham in *Journ. of Lond. School Trop. Med.*, 1911, p. 56.)

These writers claim to have succeeded in cultivating the leprosy bacillus, and

to have obtained hopeful results in the treatment of several cases of the disease by means of vaccines prepared from it.

The medium employed by Rost was a mixture of distilled volatile alkaloid of rotten fish, lemco-broth (without salt or peptone), and milk. Inoculations of this from a leproma gave a stringy growth at the bottom of the tube consisting of acid-fast bacilli in parallel arrangement. In subcultures on nutrient agar the growth was only slightly acid-fast, but it rapidly regained its acid-fastness when transferred to a medium of a fatty nature.

Similar cultures were obtained for three different cases. Inoculation experiments with cultures on monkeys produced in one case, after repeated injections, symptoms suggesting leprosy, such as a temperature of 100° to 103°, and nodules on the superciliary ridges, and elsewhere, in the contents of which masses of acid-fast organisms in parallel rows were detected.

A vaccine was prepared from the cultures, and was tried in ten cases, marked reaction and improvement resulting in all of them.

Williams has been able to grow from leprotic lesions an acid-fast streptothrix and regards the bacilli as simply broken-down streptothrix. For the growth of the bacillus he employed a medium similar to that of Rost, but in which distilled water replaced the distillate of rotten fish.

J. M. H. M.

ACID-FAST AND ACID-RESISTING GERMS CULTIVATED FROM CASES OF HUMAN LEPROSY AND THEIR DETERMINATION. H. Bayon. (*Journ. of Lond. School Trop. Med.*, vol. i, 1911, p. 45.)

By acid-fast germs the writer means germs which do not get bleached by 20 per cent. nitric acid for thirty seconds or more, after having been stained with warm carbol-fuchsin for ten minutes, and by acid-resisting germs those which withstand 2 per cent. sulphuric acid for five minutes after the same procedure. The object of this research was to attempt to determine if the germ of leprosy could be cultivated and transmitted to animals either directly or after cultivation, if rat leprosy is caused by a germ identical with that of human leprosy, and the manner of transmission of leprosy.

At the outset the writer points out that acid-fast germs are so ubiquitous, especially those of the smegma group, that any germ cultivated from cases of leprosy must be thoroughly tested as to its relationship to the disease, and too much reliance not placed on its morphological and staining properties. After a prolonged series of experiments in this connection the following results were obtained:

From the nodules of a case of leprosy Bayon succeeded in cultivating on two separate occasions an organism which became acid-fast on being injected into mice and rats. The germ was regained in pure culture, and proved not to be tubercle—human, bovine, or avian—nor smegma. It was distinguished by cultural methods from nineteen other acid-fast organisms. By injecting it in rats the identical changes of spontaneous leprosy of the rat and analogous to the lesions of leprosy in the human being were produced.

"Leprosy was transmitted directly to the rat from the human being, proving that the disease was contagious."

The complement-deviation test was adapted to the special circumstances by

preparing an appropriate antigen, and a successful differentiation was made between various germs which might have been mistaken for leprosy, proving at the same time the relationship of the bacterium cultivated to the disease.

J. M. H. M.

ORIENTAL SORE IN BAGDAD, ETC. C. M. Wenyon. (*Parasitology*, vol. iv, 1911.)

In his report of the expedition sent to Mesopotamia in 1910 by the London School of Tropical Medicine, Wenyon, the protozoologist of the expedition, comes to the following conclusions with regard to oriental sore in Bagdad:

The oriental sore as it occurs in Bagdad does not differ essentially from that of other places. It attacks practically all the natives, generally between the ages of one and three years, newcomers usually becoming infected within two years after arrival; occasionally individuals may escape infection though exposed to it for years. There may be one, two, or three sores at a time and occasionally a larger number may occur. Whether single or multiple the sore rarely appears on any but an exposed surface of the body, namely, the face, forearm, leg, hand or foot. One attack confers absolute immunity for the rest of life. It is possible that the sore of Aleppo may not produce absolute immunity against the sore of Bagdad and the same may be true of other places. From inoculation from man to man it is demonstrated that the incubation period is about two months; inoculation with the juice from a sore produced a single lesion; from this it is concluded that where multiple sores occur each is a separate inoculation.

The sores are most prevalent at the close of the hot season from September to November though they may make their appearance at any time of the year, and they usually last from twelve to eighteen months.

The sore commences as a small papule which increases in size, and either remains dry with a scaly scab on the surface, or becomes ulcerated. It is associated with neither pain nor constitutional disturbance.

In all true sores the typical parasites (*Leishmania tropica*) can be found unless the sore is in the final healing stage, but Wenyon was unable to demonstrate the presence of the parasite in the peripheral blood.

House-flies collected from the open sores of children affected nearly always show the parasites in the gut and must often act as carriers of the disease. Mosquitoes fed upon the sore are also found to take up parasites and probably transmit it. No treatment had much effect in reducing the duration of the sore.

J. M. H. M.

NODULI CUTANEI. Arning and Lewandowsky. (*Arch. f. Derm. u. Syph.*, 1911, Bd. cx, p. 3.)

The authors described under this name a disease which they maintain is relatively common seeing that they have observed twenty cases in one year among five thousand patients. It is probably related to, if not identical with, Unna's "Fibroma simplex," but owing to its causing no symptoms has been overlooked.

The disease has not been observed in children. It consists of small lumps in the cutis, measuring from 2 to 4 mm. in diameter, circular in outline, firm and lenticular in shape, well defined from the surrounding tissue and of a pink or

pinkish-brown colour. It is found chiefly on the foot on the outer side of the arch, occasionally on the forearms and shoulders, but never on the face or hands. The duration has usually been of ten or twelve years.

Microscopically it is found to be a circumscribed but not encapsuled growth of new tissue in the corium. The upper layers consist of a structureless mass which stains like collagen, and contains no elastin but small heaps of nuclei. The deeper layers are vascular. The authors have come to the conclusion that such growths may represent obsolete foci of infection. (In this case it seems curious that the hands and face, so much exposed to infection, are not sites of the disease.—A. W.)

A. W.

A CONTRIBUTION TO OUR KNOWLEDGE OF THE DYSKERATOSES. Bettmann. (*Arch. f. Derm. u. Syph.*, 1911, Bd. cx, p. 15.)

This article is *à propos* of a single case. The patient was aged 27 years and had suffered from what was almost certainly Epidermolysis bullosa, but the disease had nearly disappeared.

The backs of the hands and the knees and elbows showed the fine parchment-like atrophy common in these cases, the nails had gone and the hair was very thin. A curious point was that there was a diffuse hyperkeratosis of the palms and to a less extent of the soles. The mouth showed extensive leukoplakia. The patient had been treated freely with arsenic, but the history was quite definite in showing that the palmar and plantar hyperkeratosis had developed several years after the cessation of the drug.

A rather full discussion of the literature accompanies this article.

A. W.

THE PRESENT STATE OF THE QUESTION OF SPOROTRICHOSES. Beurmann and Gougerot. (*Archiv f. Derm. u. Syph.*, 1911, Bd. cx, p. 25.)

This is a very important article, but being itself almost entirely a collection of other publications does not lend itself to abstract.

A. W.

CONTRIBUTION TO OUR KNOWLEDGE OF ATYPICAL BULLOUS DISEASES. Bogrow. (*Archiv f. Derm. u. Syph.*, 1911, Bd. cx, p. 75.)

The patient was a girl, aged 19 years. Her father had died of diabetes, and her mother had always been delicate. The patient herself was also delicate, and her teeth showed striations.

The skin-disease, which was of fourteen months' duration, began with itching followed by blisters on the arm. The skin on the extremities, especially on the extensor surfaces, showed cigarette-paper atrophy. There were present also a good many actual bullæ, which took from three to seven days to heal. On the hands and feet the contents of the bullæ were often hæmorrhagic; the finger-nails and toe-nails were, however, normal. On the shoulders there were polycyclical rings of erythema, and the face was the seat of pigmentation and milium. The scalp was affected with impetigo. The eyes showed blepharophymosis, entropion, trichiasis, and cloudy cornea. No blisters could be determined by

hard stroking, but painting of the skin with collodion brought them out. No treatment was of any avail. The author places the disease as a connecting link between Epidermolysis bullosa and Duhring's disease.

A. W.

REVIEW.

Dermatologische Wochenschrift.*

On January 6th this new weekly journal took the place of the *Monatshefte für praktische Dermatologie*, which first appeared thirty years ago as a monthly magazine. Many years ago its success made it necessary to issue it as a bi-monthly publication, and it has since made such headway in general favour that we now have the pleasure of congratulating Professor Unna on its transformation, with a new title, into a weekly dermatological journal. The great recent advances in dermatology have made it absolutely essential to have a means of bringing new discoveries, new methods of treatment, and new deductions from clinical facts before the dermatological world without delay, and we are convinced that no better means could have been devised for this end than the establishment of the *Dermatologische Wochenschrift*. The rapid publication of important medical papers has long been a crying need, and, even if only a short abstract of such papers is published in the new journal, a certain delay in publishing the full paper in some Archiv will not so much matter. We take this opportunity of congratulating Professor Unna on the addition of two such distinguished dermatologists as Dr. Rille and Dr. Delbanco to the editorial staff.

The editorial work of the copious abstracts from current literature will still be carried on by Dr. Taenzer, and there are few journals which deal with dermatological abstracts in such an able manner. Now that the journal appears every week there will no doubt be less delay in their publication—a delay to which we ourselves sometimes have to plead guilty—for the early publication of a *resumé* of current literature we consider one of the greatest desiderata in the dermatological world at the present moment.

Of the sterling worth of the papers which have always adorned the old *Monatshefte*, and have already appeared in the first few numbers of the *Wochenschrift*, we need say nothing, for they are well known to us all.

J. L. B.

* *Dermatologische Wochenschrift.* Leipzig and Hamburg: Leopold Voss. Price 48 marks a year.

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